# PATIENT HISTORY AND ACQUAINTANCE INFORMATION-ADULT

Date_____Family Dentist_____Referred by_____

## PATIENT

Name_____
Last First Middle Preferred name

Age____Birthdate_____Sex_____Drivers License number_____Social Security_____

Address_____Phone_____

How long at this address_____e-mail address_____

Previous address(if less than 3 yrs.)_____How long?_____

Employer_____Business Address_____

Occupation_____No. Years Employed_____Work phone_____

Marital Status_____ Single _____Married _____Divorced_____Separated_____

Spouse's Name _____ Spouse's Occupation_____

Spouse's Employer_____Business Address_____Years employed_____

Spouse's Social Security Number_____Spouse's Birthdate_____Spouse Work phone_____

Name and age of children in family_____

## Dental and Medical History

Has an orthodontist been seen previously? Yes_____No_____By Whom and When_____

Have you had previous orthodontic treatment? Yes____No_____By Whom and When_____

If transferred, previous orthodontist_____

Complete address_____

Phone_____E-mail address_____

Date of Last Dental Checkup_____Were your teeth cleaned_____Yes _____No

How many times per day do you brush your teeth_____0_____1_____2_____3 Floss _____0_____1_____2

**Check Yes or No for Which You Have Been Treated or Diagnosed. If Yes, Specify Problem.**

__Yes__No Anemia
__Yes__No Blood Disease
__Yes__No Hepatitis
__Yes__No Risk group for AIDS
__Yes__No Jaundice
__Yes__No Rheumatic Fever
__Yes__No Heart Disease
__Yes__No Tuberculosis
__Yes__No Diabetes
__Yes__No Endocrine Problems
__Yes__No Bone Disorders
__Yes__No Epilepsy/Seizures

___Yes___No Herpes
___Yes___No Tonsillitis/Adenitis
___Yes___No Tonsils Removed
___Yes___No Adenoids Removed
___Yes___No Asthma
___Yes___No Mouthbreathing
___Yes___No Allergies
___Yes___No Drug Sensitivity
___Yes___No Under physician's care
___Yes___No Systemic Medicines
___Yes___No Unusual Illnesses
___Yes___No In Good Health

___Yes___No Speech Problems
___Yes___No Head/Face Injuries
___Yes___No Dental Injuries
___Yes___No Thumb/Finger Habit
___Yes___No Difficult Oral Surgery
___Yes___No Clench/grind Teeth
___Yes___No Missing/extra Teeth
___Yes___No Clicks/pops of Jaw
___Yes___No Head or Ear Aches
___Yes___No Need Premedication
___Yes___No Any Current Medicines

Specified Notes:

_____

_____

Patient's Family Physician_____Date of Last Visit_____
Would you consider your health to be:_____Excellent_____Good_____Fair_____Poor
Person To Be Notified In Case Of An Emergency:_____Phone Number_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in medical status. I authorize the orthodontic staff to perform the necessary services which may be needed.I understand that where appropriate, credit bureau reports may be obtained.

Signature of Responsible Party:_____Date:_____